Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS COUNTY HOSPITAL DISTRICT
PO BOX 12029
DALLAS TX 75225-0029

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-4224-01

MFDR Date Received
June 1, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing denial based on services rendered was on an emergency bases and the fact that they have already paid for the charges for same date of service prior to the surgery."

Amount in Dispute: $28,526.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant was admitted to the hospital not to save life or limb, but because the claimant's lower extremity wounds had sufficiently healed to proceed with the open reduction internal fixation surgery. . . . There was no emergency. . . . if you skip the preauthorization requirement you must substantiate, not medical necessity, but medical emergency. . . . For this reason Texas Mutual believes no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2010 to February 22, 2010	Outpatient Hospital Services	$28,526.78	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 47 – THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED, MISSING, OR ARE INVALID.
- 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
- 907 – NOT ALL DIAGNOSES SUBMITED ARE RELATED TO THE COMPENSABLE INJURY. ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE.
- B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
- 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Did the respondent support the denial of payment based on the requestor's failure to obtain preauthorization?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 724 – "NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK," and 786 – "DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. Nevertheless, on August 15, 2012, the Division requested the respondent to provide a copy of the referenced contract(s) between the health care provider and the alleged network pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 Texas Register 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." In a facsimile transmission, dated August 27, 2012, Coventry Health Care, replying on behalf of the respondent, stated that "No PPO discount was applied because Dallas County Hospital District was not contracted in the network at the time services were rendered." The respondent did not otherwise submit copies of the additional requested documentation. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The insurance carrier reduced or denied disputed services with reason codes 197 – "PRECERTIFICATION/ AUTHORIZATION/NOTIFICATION ABSENT;" 786 – "DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." 28 Texas Administrative Code §133.2(3)(A), effective July 27, 2008, 33 *Texas Register* 5701, defines a medical emergency as "the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." No documentation was found to support a medical emergency, nor was any documentation found to support that this surgical service had been preauthorized. The insurance carrier's denial reason is supported. Reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.